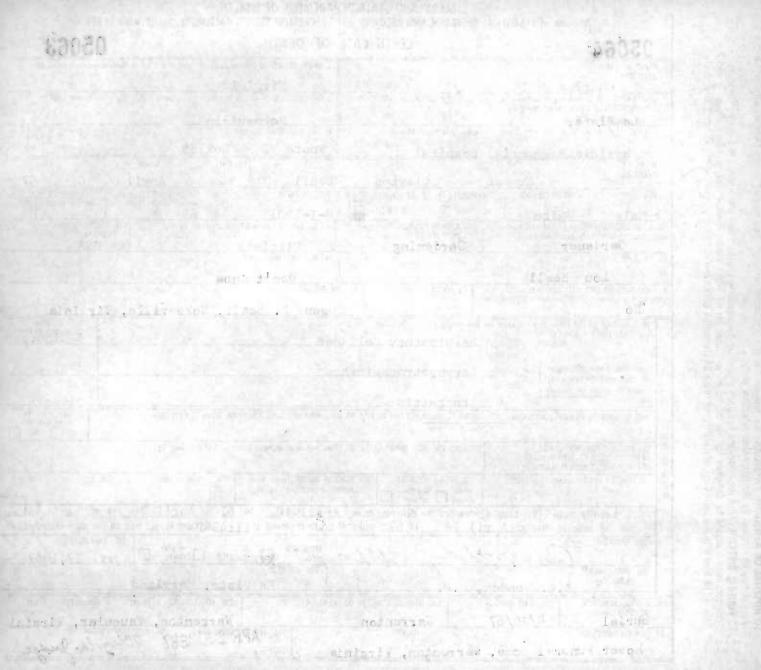
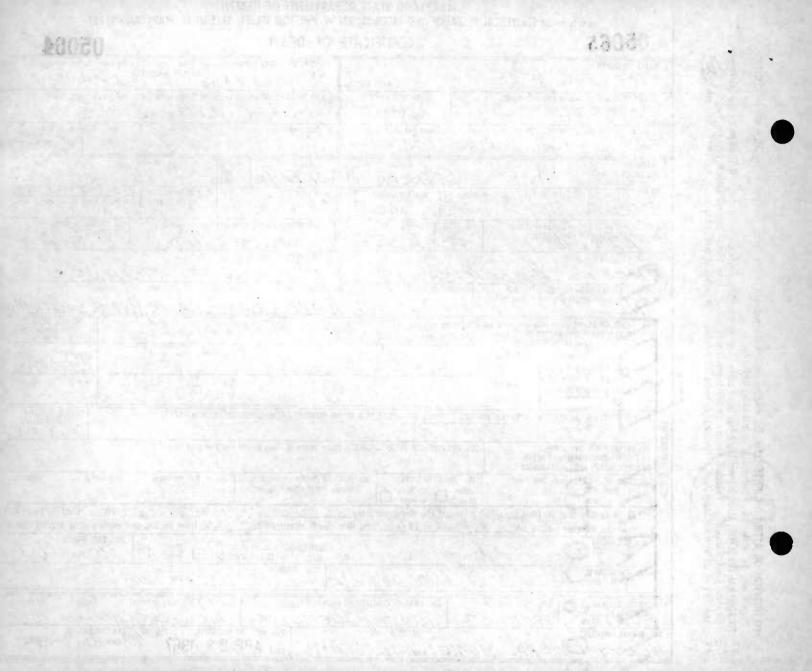
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #2 Film#G388 5. 05063 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Maryland requires that the death certificate be executed within 24 hours after the ottending physician and completely filled in by the issit permit. Then please remove corbon papers. Pages nation, or removal, and in opy event, within 72 hours aft b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write BURAL and give negrest town Charlotte Hall d. NAME OF HOSPITAL OR INSTITUTION Ut nat in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO NAME OF First Middle 4. DATE Lost Month Year DECEASED Lerson Horace 19 (Type or print) DEATH SFX 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED DATE OF BIRTH last_birthdoy) Manths Davs WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY SENERAL SERVIC FATHER'S NAME 14. MOTHER'S MAIDEN NAME buriol, cremation, or removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates af service 16. SOCIAL SECURITY NO. 17. INFORMANT Address CIARRIOTTE HALL MARULA INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o) (b), and (c).) buriol-tronsit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY ereprovascul IMMEDIATE CAUSE (a) signed by Poge 4 may be retained by the hospital or ottending physicion. DUE TO Cardiovascular Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause this certificate hos been the last. 00 WAS AUTOPS!
PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 3 should be detached for use with the Stote Dept. of Health melitus NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) (State) factory, street, affice bldg., etc.) Haur a.m. Not While While at work at work TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased fram 1967 to 1967, that (1) (we) last and that death accurred at 705 M, from causes and an the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22a. SIGNATURE M.D. DIRECTOR PHYS director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) **BURIAL CREMATION** 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOYAL (Specify) 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05065 CERTIFICATE OF DEATH 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) and give nearest tawn) NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES PNO [requires that the death certificate be executed within NAME OF Middle 4 DATE Day Year DECEASED RROOK BANK and campletel ENCER DEATH and in any event, (Type or print) remave car IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED 9. AGE (In years NEVER MARRIED birthday) Manths Days Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) physician ER 13. FATHER'S NAME 14. MOTPLER'S MAIDEN NAME cremation, ar remaval, en WAS DECEASED EVER IN ILS ARMED FORCES? 17 INFORMANT (Yes, no, ar unknown) (If yes give war or dates of service VDE BROOKBAN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if ony, which gove Minona rise ta immediate cause (a) DUE TO stating the underlying couse as the last. WAS AUTOPS) PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION far use of Health NO this certificate 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II af item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City ar tawn) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year Hour a.m. factory, street, office bldg., etc.) While Not While at wark ot wark 21. I certify that (1) (this haspital) attended the deceased fram 22 . 1967, ta 24 20m-1, 196/, that ()) (we) last director, page 3 should should be filed with the 19 (66, and that death accurred at 9.13 34M, from causes and on the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an_ 22a. SIGNATUR 22b. DATE SIGNED **ATTENDING** PHYS DIRECTOR M.D. 22d. ADDRESS 79 PHYSICIAN'S O HOSPITAL NAME (Type) 23b. DATE THEREOF OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION (County) (State) REMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05066 MEDICAL EXAMINER'S CERTIFICATE . PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Charles a. COUNTY o. STATE Maryland Charles and 2 with the State Department af MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) La Plata PM3. Forest Park, Waldorf d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? with farm Physicians Menorial Hospital YES NO DO This certificate should be executed within 24 haurs after death. 3. NAME OF Middle 4. DATE Last Manth Day Year DECEASED Clark April Randall 6 67 George (Type or print) DEATH e, writing the ward "pending" in pencil in Item 18. Give farwarded ta the Chief Medical Examiner's Office alang B DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months 9/6/40 Male White WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even the tired)

Propellant Handler 11. BIRTHPLACE (State or foreign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? WASHINGTON, D.C. Government pages in pencil i 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT (Yes, no, orunknown) (If yes give war or dates of service any event within 18. CAUSE OF DEATH (Enter only one cause per line for (a). burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH - RESPIRATORY DUE TO Conditions, if ony, which gove rise to immediate cause (a), .⊑ DUE TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY ar remaval, PERFORMED? unad Page 4 shauld be 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3 shauld PRIMARY ar CONTRIBUTING CAUSE OF DEATH crematian, 20c. TIME OF INJURY Month, Pay, Year 20e. PLACE OF INJURY (Hame, farm, (City or town) County) / (State) Not While at wark factory, street, affice bldg., etc.) 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion Inspection death resulted from: Noturol couses Accident V Suicide Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SGNED ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Health 1 Address (Street, city, tawn, ar caunty) 0 VR A15ME (5) 6M 1/67

State of the state

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

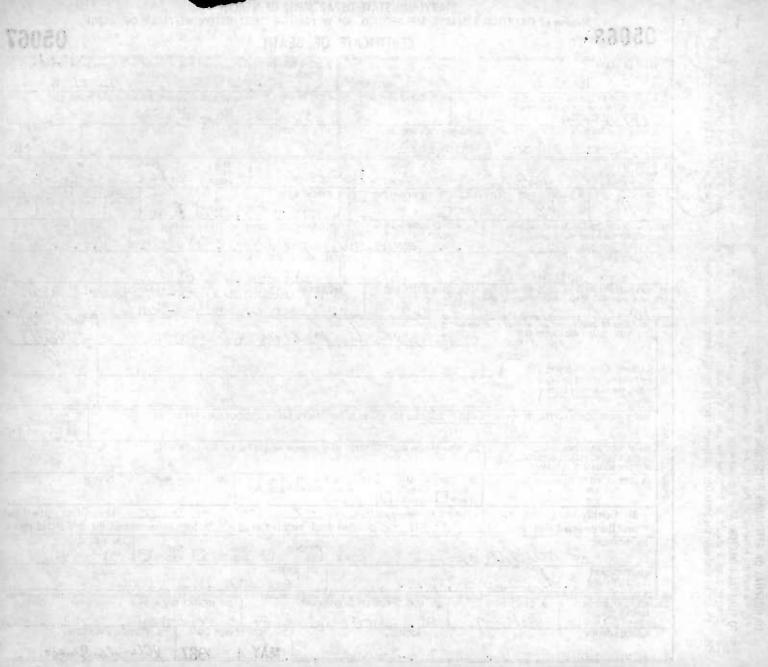
MEDICAL EVAMINED'S CEDTICICATE OF DEATH

05066

LOKOLANI		00001		MED	ICAL EXAMINER	3 CERTIFICATE	OF DEATH	00000
IEALTH DEPT.	1.	PLACE OF DEATH					(Where deceosed lived, if instituti	
luy is 13 ta Page ent af		a Charle	es		MARYLAND	Maryla	nd b. COUN	Of the last
d 3 d 3 . Po		b. CITY OR TOWN (If autside carparate limi	ts,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If o	autside carporate limits, write RUF	RAL and give nearest tawn)
y del and m3.	1	lughesv	d give neorest town)		15-Yrs	Hughe	sville Md	08-1
ficate shauld be executed within 24 hours after death. If any ing the ward "pending" in pencil in Item 18. Give Pages 1, 2, orded ta the Chief Medical Examiner's Office along with farm PN as a burial-transit permit. File pages I and 2 with the State Depart and in any event within 72 haurs after death			TAL OR INSTITUTION (If n	ot in hospitol, g	ive street oddress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO X
			ary Beatr	irst ice Da	Middle	Last	4. DATE OF 4-1-67	19
		Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	DIVORCED [B. DATE OF BIRTH 9-7-1923	9. AGE (In yeors lost birthdoy) 43 yrs.	IF UNDER 1 YEAR
	du	ing mast of working Housewi	N (Give kind of work done life, even if retired) f e	10b. KI IN	ND OF BUSINESS OR DUSTRY		Wine Md	12. CITIZEN OF WHAT COUNTRY?
	-		ward Broo			14. MOTHER'S MAIDEN Alice	Gray	
			R IN U.S. ARMED FORCES? (If yes give war or dotes		SOCIAL SECURITY NO. 1	John F. Da	vis-Husband	Hughesville Md
		PART I. DEA	EATH (Enter only one ca TH WAS CAUSED BY: IMMEDIATE CAUSE	(a) Cor	(a), (b), and (c).) Onary Occlu	sion		INTERVAL BETWEEN ONSET AND DEATH Immediate
		Conditions, if ony rise to immediat	which gove		eriosclero	sis Genera	1	Indefinite
		stoting the unde	riying couse	(c) Agi	ing process			Indefinit
This certicate, write be farwar be used remaval,	CATION			CONTRIBUTING T	O DEATH BUT NOT RELATED T	TO THE TERMINAL DISEASE CO	ONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED? YES NO
NNER: ne certifi should files. 3 shauld itian, ar	MEDICAL CERTIFICATION	20o. EXTERNAL CA PRIMARY ☐ or CO CAUSE OF DEATH.		20b. DE	2 15 M		n Part I ar Part II af item 18.)	
		20c. TIME OF INJU Haur a.r p.r	10	20d. IN While of work	Not While	PLACE OF INJURY (Hame, far foctary, street, affice bldg., et		(Caunty) (State)
Pag Pag ar y R: P		21. I certif	y that I taok charg	e af the ren	noins described above,	held an Autopsy	, Inspection , Inqu	iry 🙀 and in my apinia
tar. tar. cro		deoth resul	ted from Natur	al causes :	🖈, Aecident 🗌, S	uicide, Homicid		anner
MEDICAL EXAN please execute tl I directar. Page 4 retained far yaur L DIRECTOR: Page ar ta burial, cremo	<	ACTU AL SIGNATURE	1	25	ee		EDICAL EXAMINER	22. DATE SIGNED
TO DEPUTY MEDICAL ES necessary, please executhe funeral directar. Pag 5 may be retained far 10 FUNERAL DIRECTOR: Health priar ta burial, a	2	EXAMINER'S NAME (Typy 2	mes E.And	irews 1	MD	DEPUTY MEDI Address (Stre	CAL EXAMINER	4-1-1967 Lan Head Md
o Di the 5 mc 6 FU	23	a. BURIAL, DEMATIC	ON, 23b. DATE TH	IEREOF	23c. NAME OF CEMETERY	OR CREMÁTORY	23d. LOCATION (City or To	wn) (County) (State)
- 5-		REMOVAL(Specify		4,1967		Church Cem.	Brandywine,	Pr. Geo. Md.
VP A I SME (5)	2	4. FUNERAL DIRECTO	Adame	Acuro	ADDRESS ADDRESS	ZSa. REC	D BY REGISTRAR 2Sb. RE	GISTRAR'S SIGNATURE

33030 The fire out the saving at - ... gives actually they ---MY MARK TORRES Table -8711 -87110 - 1100 - 11 John V. Davis ellumbant Hogs sevi blacker. the first of the f final selection of the vileada kas vessour aug Tanna Tanan Tanan Successful Mountain mountain hours are selected that are allowed to a substitute of the selection of the sel The Total Commence to the Section of the Section of

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05068 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH attending physician and completely filled in by the funeral permit. Then please remove carbon popers. Pages I and o. COUNTY b. COUNTY o. STATE within 72 hours after de Charles Charles MARYLAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b write RURAL and give necrest town) Potomac Heights IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Physicans Memorial Hospital YES NO IX 3. NAME OF DECEASED Middle 4. DATE Dov Year 5. DUDLEY 196 event, (Type or print) DEATH 9. AGE (In years S. SEX 8. DATE OF BIRTH 6. COLOR OR 7. MARRIED NEVER MARRIED Months lost birthdoy) Hours DIVORCED WIDOWED January 23 buriol, cremation, or removal, ond in ou 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) INDUSTRY Virginia Gaverment Lynchburg Retired 14. MOTHER'S MAIDEN NAM 13. FATHER'S NAME Elizabeth Eacls Lee Dudley 16. SOCIAL SECURITY NO. 17 MNEORMANTElizabeth Eck-Dawhter-Indian 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) Elmer L. Dudley-Son None INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c), burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (g) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse Poge 4 may be retained by the hospital or ottending director, page 3 should be detached for use as the shauld be filed with the State Dept. of Health prior to O FUNERAL DIRECTOR: After this certificate hos been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) Hour o.m. Not While factory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased fram 4: -7, 1967 sow the deceased olive on 4 - 30, 19 , and that death occurred at 2 P , 1967, that (I) (we) last 196 / to. 4-20 M, from causes and an the date stated abave. sow the deceosed olive on. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) M.D. La Plata , Maryland Johnson 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) 23o. BURIAL CREMATION. REMOVAL (Specify) Pomonkey Maryland John's Cemetery 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Marila Archart Funeral Home Inc - La Plata



any delay is

in pencil in Item 18. Give Pages 1, 2, and 3 to. the Store Deportment of PM3. Page necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, ,' the funerol director. Page 4 should be forworded to the Chief Medical Examiner's Office along with form 5 may be retained far your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages land 2 with Health prior to buriol, cremation, or removal, and in any event within 72 hours after death.

This certificate should be executed within 24 hours ofter death. If

TO DEPUTY MEDICAL EXAMINER:

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05069

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH O. COUNTY	CHARLES	MARYLAND	CTATE	(Where deceosed lived, i	I COLINITY	n 15068 m) narles
	(If outside corporate limits, and give pearest_tawn)	c. LENGTH OF STAY IN 1b		outside corporate limits,	write RURAL and gir	ve nearest town)
	LaPLata			hesville	13	8.
	'ITAL OR INSTITUTION (If not in hospital, g		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
Phys	sician Memorial Ho	spital	Goo	d Road		YES NO P
3. NAME OF DECEASED	First	Middle	Lost	4. DATE OF	Month	Doy Year
(Type or print)	JAMES		EDELEN	DEATH	April .	14, 19 67
S. SEX	6. COLOR OR RACE 7. MARRIED	☐ NEVER MARRIED ☒	B. DATE OF BIRTH	9. AGE (In lost birt		Doys Hours Min.
Male	Negro WIDDWED	DIVORCED	Jan. 16, 19	167	yrs. 3	V 10015
during most of workin		ND OF BUSINESS OR DUSTRY	La Plata	Chas.		ITIZEN OF WHAT OUNTRY?
13. FATHER'S NAME			Haa M.	Butter		
15. WAS DECEASED EV (Yes, no, or unknown	VER IN U.S. ARMED FORCES?) (If yes give wor or dotes of service)	SOCIAL SECURITY NO. 17.	informant	+ Good K	Address Hug	pesuille,
	DUE TD oy, which gove) (b) ote couse (o), Dur to	(o), (b), ond (c).) Interstitial p	neumonitis	(SDII)		INTERVAL BETWEEN DNSET AND DEATH
PART II. OTHER	SIGNIFICANT CONDITIONS CONTRIBUTING 1	D DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO	ONDITION GIVEN IN PART	T 1(o)	19. WAS AUTOPSY PERFORMED? YES X NO
ABOLOM STREET S	ONTRIBUTING	SCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in	Port I or Port II of iten	n 18.)	
	o.m. While of work	Not While of work	ACE OF INJURY (Home, for tory, street, office bldg., etc	.)	town) (Co	ounty) (State)
	ify that I took charge of the renulated from: Notural courses		cide, Homicide CHIEF MEDICAL	e, Undeterm	Inquiry, ined monner _	ond in my opinion 22. DATE SIGNED
EXAMINER'S NAME (Type)	Charles S. Sprin	ngate, M.D.	DEPUTY MEDIC Address (Stree	CAL EXAMINER et, city, town, or county	Apr	il 14, 1967
230 BURIAL CREMAT REMOVAL (Speci	W 4-17-67	23c. NAME OF CEMETERY OR St. Philip ADDRESS	Ch. Cem.	23d. LOCATION (C	ity or Town) 25b. REGISTRAR'S	(County) (State)

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH EALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence charles o. STATE Maryland b. COUNTY Charles the State Department of MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b Port Tobacco La Plata d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE ON A FARM? YES NO A d. STREET ADDRESS Office along with farm Physicians Memorial Hospital in Item 18. Give Pages be executed within 24 haurs after death. NAME OF Middle First Lost 4. DATE Month Doy Year DECEASED OF DEATH 19 67 SHIRLEY FERRIS 3 (Type or print) Z with. IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED X NEVER MARRIED lost birthdoy) 46 yrs. Months Hours July 12, 1920 WIDOWED DIVORCED Female White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if ratired)
HOUSE WITE within 72 hours after Winterset, Iowa the Chief Medical Examiner's pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Walter Cord Bessie Davis IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no or unknown) (If yes give wor or dotes of service) pending" Mr. William J. Ferris-Port Tobacco. Mc Unkown INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY ONSET AND DEATH any event Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (o) This certificate shauld e, writing the ward farwarded to the Ch DUE TO Conditions, if ony, which gove rise to immediate couse (o), E DUE TO stoting the underlying couse pup last be used 19. WAS AUTOPSY PERFORMED? remaval, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERTIFICATION the certificate, YES X NO shauld be 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 should crematian, ar PRIMARY Or CONTRIBUTING CAUSE OF DEATH. MEDICAL 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Year (County) (Stote) foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page of work 21. I certify that I taak charge of the remains described above, held an Autapsy X Inspection | Inquiry and in my apinian death resulted fram: Natural causes X Accident Suicide Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER Health priar to 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER 4-3-67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) WERNER U. SPITZ. 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREO 23d. LOCATION (City or Town) (County) 50 BEMOVAL (Specify) 4/6/1967 Waldorf, Trinity Memorial Maryland Gardens 24. FUNERAL DIRECTOR VR A15ME (5) Funeral Home, Inc .- La Plata, Md. 6M 1/67

**** personner the expension of the last of the actions the same of the discount to the action of the first , ..., ATA 11 1961

FOR S

the State Department of

necessory, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office olong with form PM3. Page This certificate should be executed within 24 hours ofter death. If any delay is 5 may be retoined for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a buriol-tronsit permit. File pages land 2 wit Health prior to buriol, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER:

VR A 15ME (5)

05071

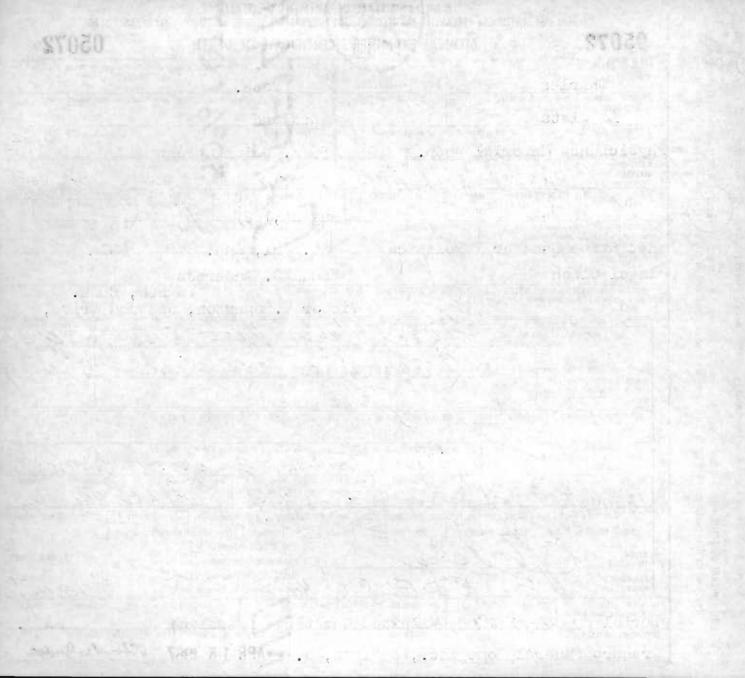
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05070

ACE OF DEATH COUNTY Charles	MARYLAND	a CTATE	Where deceosed lived, if it and	COUNTY	nce before odmi harles	ission)	
CITY OR TOWN (If autside carporate limits.	c. LENGTH OF STAY IN 1b			rite RURAL ond giv	e nearest town)	
write RURAL and give nearest tawn) Wayside		Ways	side		1.1	18.1	
NAME OF HOSPITAL DR INSTITUTION (If not in hospite	ol, give street oddress)	d. STREET ADDRESS			-QN	ESIDENCE A, FARM?	
ECEASED TAMES	Middle W •	lost GREEN	4. DATE OF DEATH	Month April	Doy 12	Year 19 67	
X 6. COLOR OR RACE 7. MARRI	NEVER MARRIED					DER 24 HRS.	
Iale Negro widdw	ED DIVORCED		1904 66	yrs.	Doys Hou	rs Min.	
	KIND OF BUSINESS OR						
Ernest Green							
WAS DECEASED EVER IN U.S. ARMED FDRCES? no, or unknown) (If yes give war ar dates of service)	16. SOCIAL SECURITY NO. 17. 1 220-40-73 2						
IMMEDIATE CAUSE (o) HYP DUE TO Conditions, if ony, which gove yise to immediate cause (o), stating the underlying cause (c) (c)					Tio Was a	ULTODEV	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION	IG TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE COL	NDITION GIVEN IN PART	1(0)	PERFO YES E	RMED?	
PRIMARY or CONTRIBUTING	DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in	Port I or Port II of item	1B.)			
Hour o.m. W	hile Not While foct			wn) (Co	unty)	(Stote)	
		ide, Hamicide CHIEF MEDICAL	, Undetermin		22. D/	ate SIGNED	
EXAMINER'S Charles S. Pet		DEPUTY MEDICA	AL EXAMINER		47	12/67	
	AME OF ECEASED Type or print) EX 6. COLOR OR RACE TO MIDDWI USUAL OCCUPATION (Give kind of work done g most of working the even if retired) FATHER'S NAME ETNEST Green WAS DECEASED EVER IN U.S. ARMED FDRCES? And, or unknown) It yes give war ar dates of service) IB. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (o), stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING 20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20b. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 10b.	NAME OF HOSPITAL DR INSTITUTION (If not in hospitol, give street oddress) NAME OF HOSPITAL DR INSTITUTION (If not in hospitol, give street oddress) AME OF	Ways Ways Ways Ways Ways Ways Ways NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS AME OF ECEASED JAMES First Widdle Was Ways Ways Was Was	Wayside NAME OF HOSPITAL DR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS	NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) AME OF HOSPITAL DR IN HOSPITAL CAUSE OF HOSPITAL DR IN	Wayside Wayside Wayside NAME OF HOSPITAL DR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS J. R. R. STREET ADDRESS J. R. R. STREET ADDRESS J. R.	

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05072 05072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY 3 ta death. Charles MARYLAND b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If gutside carparate limits, write RURAL and give nearest tawn) pup write RURAL and give nearest town) Ashland d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM haurs Physicians Union Street NO Memorial NAME OF DECEASED DATE Give DEATH within S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 889 AGE (In years himiday) Months in Item 18. WIDOWED DIVORCED 1880 Office P 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during mast af working life, even if retired) INDUSTRY COUNTRY? pages I Ret State Senator
13. FATHER'S NAME Politics St. Paul Minn pencil be executed within Ingel Olson Hanna C. Anderson VERNOWS CONN. 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no prunknawn) (If yes give war ar dates af service remayal, Victor V. Magnuson, Rosewood Drive. 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY D IMMEDIATE CAUSE (a) certificate shauld Ward crematian, DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO D stoting the underlying couse used as burial, a as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? please execute the certificate. YES agent, priar ta be 20b. DESCRIBE HOW INJURY OCCURRED LEgter notifie of injury in Part I or Part II of item 18. 20a. EXTERNAL CAUSE WAS 3 shauld PRIMARY Or CONTRIBUTING O DEPUTY MEDICAL EXAMINER: CAUSE OF DEATH Zactory, street office bldg., etc.) 20c. TIME OF INJURY Month, Doy, Year (State) (Count Not While FUNERAL DIRECTOR: Page at work 21. I certify that I took charges of the remains described above, held on Autopsy Inspection ond in my opinion Natural causes death resulted from Accident Suicide Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** O FUNE Health NAME (Type) Address (Street, city, town, or county) 230. BURIAL, CREMATION. 23d. LOCATION (City or Town) (County) Burial (Specify) Wildwood Cemetery Ashland 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15ME (5) Otheretas Judge DATE APR Arehart Funeral Home Inc. La Plata Md. 6M 1/66



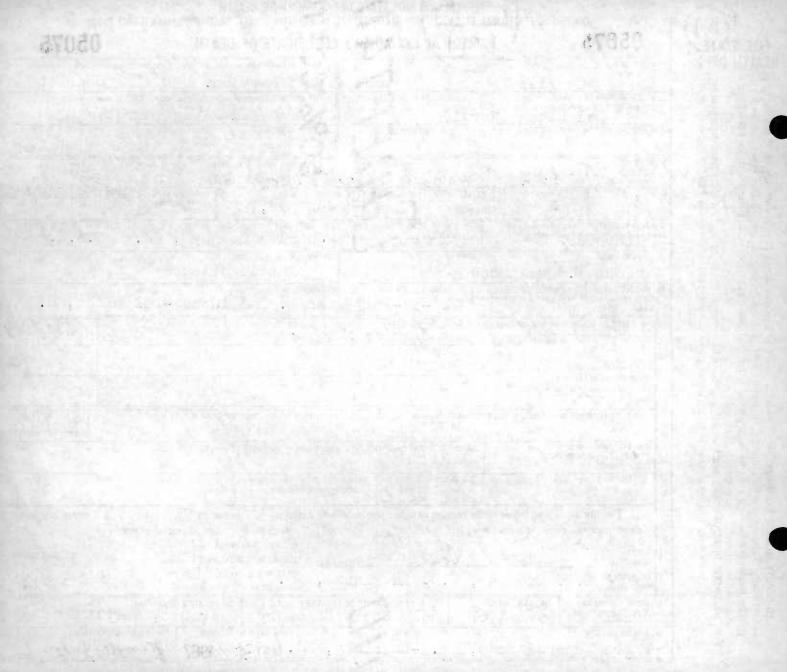
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 18 05073 I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY b. COUNTY CHARLES MASSACHUSETTS 2 0 MARYLAND delay State Deportment b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ASHLAND LAPLATA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? with farm Physician 59 North Union Street Poges LA PLATA Hospital NO K be executed within 24 hours after deoth. NAME OF Middle OLSON . First 4. DATE Month Year DECEASED OF in Item 18. Give OLSEN 19 67 Victor E. April (Type or print) DEATH Office along S. SEX B. DATE OF BIRTH 9 SAGE (In years Blast birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months DIVORCED ony event within 72 hours ofter death WIDOWED 110.11 Male White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY COUNTRY?** Walstalchyslett Minn d "pending" in pencil in Chief Medical Exominer's Security Officer-State of Mass. permit. File pages IISA 13. FATHER'S NAME Ingel Olson Hannah C. Anderson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Braintrees Mass. (Yes, no, or unknown) (If yes give wor or dotes af service Beatrice Baker, 224 Common St. es 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Fracture of thoracic vertebral column IMMEDIATE CAUSE (a) This certificate should e, writing the word farwarded to the Ch with laceration of two intercostal arteries DUF TO Conditions, if ony, which gave and right hemothorax rise to immediate couse (a) = DUE TO stoting the underlying cause D. 00 19. WAS AUTOPSY PERFORMED? or removal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) please execute the certificate, YES X NO 20o. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 should CAUSE OF DEATH Driver in auto-auto collision cremation, 20c. TIME OF INJURY Manth, Dov. Year 20e. PLACE OF INJURY (Home, form, 20f. (City ar tawn) (County) (Stote) foctory, street, office bldg., etc.)
Highway Nat While FUNERAL DIRECTOR: Poge 4-9-6719 of work of work La Plata, Charles Co., Md. 21. I certify that I taak charge of the remains described above, held an Autapsy Inquiry , Inspection and in my apinian Natural causes death resulted from: Accident DC Suicide . Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED TO FUNERAL D SIGNATURE DEPUTY MEDICAL EXAMINER April 10, 1967 Charles S. Springate, M.D. **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. (County) (Stote) BREMOYAL (Specify) April 13,1967 Wieldwood Cemetery Ashland, Mass. 24. FUNERAL DIRECTOWaters Funeral Home shahland Masson REC'D BY REGISTRAR Arehart Funeral Home, Inc., La Plata, Md. 14PR 17 196 2Sb. REGISTRAR'S SIGNATURE VR A15ME (5) 6M 1/67

20

, . . . -1207 - William Death . 111. (a) et un -1202 William - 1207 - 1208 a call legge . E NE BO AA ('lexae com') E La Flagge Chief Chief Control of the Buttal and the transfer of the Winds of the Control

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE CERTIFICATE OF DEATH CERTIFICATE OF DEATH funeral and 2 death. death. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY after MARYLAND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENCTH OF STAY IN 1b write RURAL and give nearest town) hours DORF NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE filled d. STREET ADDRESS ON A FARM? within NO S YES completely pou NAME OF Month Middle DATE Day Year DECEASED OF DEATH remove carb (Type or print) executed ACE (In years | IF UNDER 1 YEAR 6. COLOR OR RACE IF UNDER 24 HRS DATE OF BIRTH 7. MARRIED **NEVER MARRIED** last birthday) Months Days Hours and CAU WIDOWED A DIVORCED physician an please royal, and in = 10a. USUAL OCCUPATION (Cive kind of work done) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? certificate Iding phy Then pl removal, 13. FATHER'S NAME MOTHER'S MAIDEN NAME WENS has been signed by the attending as the burial-transit permit. The prior to burial, cremation, or rem HENRY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address death (Yes, no. or unknwn) (If yes give war or dates of service) INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line tof (a), (b), and (c). PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Cenditions, If any, which (b) gave rise to immediate **DUE TO** cause (a), stating underlying cause last. (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) certificate hashed for use of Health p PERFORMED? NO X YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) this certifetached for Dept. of MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) be de State Hour a.m. While Not While After retained by at work at work 19 should ith the 0 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should led with the and that death occurred at M, from the causes and on the date stated above. saw the deceased alive 22b/ DATE SIGNED 22a. SICNATURE STAFF director, page should be filed DIRECTOR M.D. PHYS. PHYS. Page 4 may O HOSPITAL FUNERAL 22c. PHYSICIAN'S ADDRESS NAME (Type) CEMETERY OR CREMATORY NAME OF (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. 23d. LOCATION (City, town or county) REMOVAL (Specify) 10 ADDRESS REC'D BY RECISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Charles Maryland hours ofter deoth. Charles MARYLAND Department b. CITY OR TOWN (If outside carparate limits. c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Bel Alton (Rural) Rural Bel Alton d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A EARM? d. STREET ADDRESS rd "pending" in pencil in Item 18. Give Poges 1, Chief Medical Exominer's Office olong with form pencil in Item 18. Give Poges ate YES 4- NO be executed within 24 hours after deoth. with the Stowinsky 3. NAME OF First_ Middle Last 4. DATE Month Day DECEASED (Type ar print) DEATH S. SEX 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR 7. MARRIED 209 birthday) June 17, 1942 Manths Days Haurs WIDOWED DIVORCED event 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during mast of working life, even if retired) Marming COUNTERS? A Charles County . Md. in ony 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mattie Briscoe John W. Smallwood puo 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, p.g., ar unknawn) (If yes give war ar dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT or removal. 220-38-1627 John W. Smallwood -Bel Alton, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), shot(c).) INTERVAL BETWEEN ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) This certificate should pleose execute the certificate, writing the word director. Poae 4 should be forworded to the Cl buriol, cremotion, DUF TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause 00 last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS! PERFORMED? NO YES 0 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) designoted ogent, prior should PRIMARY OF CONTRIBUTING CAUSE OF DEATH 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) 20c. TIME OF INJURY Month, Day, Year (County) (State) factory, street, office bldg., etc.) moy be retained for your FUNERAL DIRECTOR: Page at wark 21. I certify that I took charge af the remains described above, held on Autapsy Inspection X Inquiry XX and in my opinion the funeral director. death resulted fram: Accident . Suicide Homicide Matural causes Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEBUTY MEDICAL EXAMINER EXAMINER'S Edelen , M.D. La Plata Address (Street, city, town, or county) Heolth NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 50 BIREMOVAL (Specify) 5/2/1967 Issue , Maryland Holy Ghost Cemetery 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15ME (5) Arehart Funeral Home, Inc. -La Plata, Md May 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

d within 24 haurs after death. If any delay is in pencil in Item 18. Give Pages 1, 2, and 3 ta

This certificate shauld be executed within 24 haurs after death. If

TO DEPUTY MEDICAL EXAMINER:

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09497

OR STATE		MEDICAL EXAMINE	R'S CERTIFICATE O	F DEATH	03431				
in Item 18. Give Pages 1, 2, and 3 to Provide along with farm PM3. Page H ss 1 and 2 with the State Department of the other decision.		PLACE OF DEATH O. COUNTY Charles MARYLA	o. STATE	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE b. COUNTY Charles					
		b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) La Plata	tb c. CITY OR TOWN (If au	c. CITY OR TOWN (If autside carparate limits, write RURAL and give nea					
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO				
		NAME OF First Middle DECEASED (Type or print) CALVIN	lost WARREN	4. DATE Manth OF Apri					
office along		Male Negro WIDOWED DIVORCED	B. DATE OF BIRTH	last birthday)" N	FUNDER 1 YEAR IF UNDER 24 HRS. Manths Days Haurs Min. 1				
in Item 18 er's Office of offer decta	duri	USUAL OCCUPATION (Give kind at wark dane ng mast at warking lite, even if retired).	11. BIRTHPLACE (State	Co. NID.	12. CITIZEN OF WHAT COUNTRY?				
pencil xamin ile pag hours		FATHER'S NAME UNKOWN		KOWN.					
Medical Exemple 1 permit. Fi	(Ye	was deceased ever in U.S. ARMED FORCES? s, no grunknawn) (If yes give was as dates af service) 16. SOCIAL SECURITY NO.	17. INFORMANT	Address					
rd "pending" Chief Medical transit permit		TB. CAUSE OF DEATH (Enter anly one couse per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO	neumonitis. (S	SDII)	INTERVAL BETWEEN ONSET AND DEATH				
wa the the any		Conditions, if any, which gove his to immediate cause (a), (b)							
ting 1 rrded as a and		stating the underlying cause (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATE	TO THE TEDMINAL DISEASE COL	IDITION CIVEN IN PART 1/a)	19 WAS ALITOPSY				
icate, writ be farwar d be used remaval,	CERTIFICATION				19. WAS AUTOPSY PERFORMED? YES NO				
or r	AL CERTIF	PRIMARY \(\) or CONTRIBUTING \(\) CAUSE OF DEATH.	JRRED. (Enter noture of injury in I						
e the e 4 sl aur fi	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at wark at wark	De. PLACE OF INJURY (Hame, farm foctory, street, office bldg., etc.)		(Caunty) (State)				
exect r. Por rial,		21. I certify that I took charge of the remains described above death resulted from: Notural couses X Accident ,	ve, held on Autopsy X, Suicide , Homicide CHIEF MEDICAL	Company /					
iry, please eral director be retained RAL DIRECTORISE prior to bu		ACTUAL SIGNATURE Charles) Feng		ICAL EXAMINER	22. DATE SIGNED 4/9/67				
necessary, the funera 5 may be 6 FUNERA Health pri	02 -	EXAMINER'S NAME (Type) Charles S. Petty (Burial remation, 23b. Vate thereof 23c. Name of Cemeter	Address (Street	, city, town, or county)					
To The Hee		REMOVAL (Specify) 4/11/67 Hill	To P	23d. LOCATION (City or Town)	(County) (Stote)				
VR A15ME (5)		FUNCAL H	LOW 2 DATE	L 2 6 1967 2 2	certes judge				

Clarke Co. War to Care War of Wy Tett a Sidu.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05076 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **FOR STATE** HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Resider Charles a. STATE b. COUNTY 0 death. Washington D.C. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) Indian Head Md d. STREET ADDRESS 0 29 Hanna Place.S.E d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE ON A FARM? haurs arn YES NO K K ate Pages Carlisle hours after death. 3. NAME OF Middle 4. DATE Year Lost Month Carolise DECEASED Williams. Jr. 4-10-67 8. Give 19 (Type or print) within DEATH NEVER MARRIED IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 7. MARRIED last birthdoy) Male Months 8 Hours Negro 9-1-1957 WIDOWED DIVORCED and 2 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) during most of working life, even if retired) Washington D.C. COUNTRY? Mone any None USA pages in any pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within and INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? remaval. (Yes, no, or unknown) (If yes give wor or dotes of service) Sheriff; s Office LaPlata Md pending" None No None 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) Fatal Submersion OF e, writing the ward farwarded ta the Cl cremation, This certificate should DUE TO Canditians, if any, which gove rise to immediate cause (o), DUE TO stoting the underlying couse last. burial, WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Was fishing from a boat of Marshall Md. 3-12 67 Disappeared NO the certificate. priar to 2Da. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) should PRIMARY OF CONTRIBUTING CAUSE OF DEATH. agent, 2De. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (City or tawn) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m FUNERAL DIRECTOR: Page of work at wark its designated 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection X Inquiry Ty and in my apinion Natural causes -Accident death resulted from: Suicide Hamicide Undetermined manner may be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER 4-10-67 TO DEPUTY DEPUTY MEDICAL EXAMINER 0 EXAMINER'S Indian Head Md James Address (Street, city, town, or county) NAME (Type) E. Andrews MD CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATOR' 0 REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR ATSME (5)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05077 05077 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH AG PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY deloy is ond 3 to o. STATE b. COUNTY Page MARYLAND C. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PM3 write RURAL and give nearest town) alden tofe Depart d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE d. STREET ADDRESS in Item 18. Give Poges 1, Office olang with form ON A FARM? YES NO TO This certificate should be executed within 24 hours after death. NAME OF 4. DATE Middle Month First Dov Year DECEASED OF DEATH with the Type or print IF UNDER 1 YEAR IF UNDER 24 HR S. SEX OLOR OR RAC MARRIED B DATE OF BIRTH AGE (In years (gst birthdoy) Months Dovs Hours hours after death WIDOWED DIVORCED lond2 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) ING the Chief Medicol Exominer's pages 13. FATHER'S NAME pencil File IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT permit. (Yes, no, or unknown) (If yes give war or dotes of service 'pending" within INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), burial-transit PART I. DEATH WAS CAUSED BY ONSET AND event IMMEDIATE CAUSE (o) writing the word DUE TO Ony Conditions, if any, which gove rise to immediate couse (a), 0 _⊆ DUE TO stating the underlying couse 0 forwarded ond OS lost. nsed WAS AUTOPSY PERFORMED? removol, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH/SUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) certificate, NO 4 pe should be 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 3 should PRIMARY Or CONTRIBUTING cremation, or EXAMINER: CAUSE OF DEATH. 20e. PLACE OF INJURY (Home, form, 20f. 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED (City or town) (County) (State) Hour a.m. foctory, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Poge Page 1 of work please execute ot work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion Noturol couses deoth resulted from: Accident Suicide Homicide Undetermined monner the funeral directar retained CHIEF MEDICAL EXAMINER 0 ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMI SIGNATURE Heolth prior pe DEPUTY MEDICAL EXAMINER **EXAMINERIS** Address (Street, city, town, or county) NAME (Type 23o. BURIAL CREMATION 0 -29-6 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b. VR A15ME (5) + FUNERAL HOME 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

22030 22,030 13 6.45 3 MH-458AA Ewil Murney 73 THE THE PARTY OF T